LOUISIANA PATIENT'S COMPENSATION FUND
CORPORATION APPLICATION

(for those with underlying self-insurance and primary insurance)

NAME AND PHYSICAL ADDRESS OF CORPORATION

(Please designate whether it is APMC, AMC APC, INC, LLC, LLP, Trade Names, etc.)

_____

_____

_____

_____

DATES OF ENROLLMENT APPLYING FOR: _____

(Must coincide with dates of underlying coverage)

LIST ALL LOUISIANA HEALTHCARE PROVIDERS, WHO ARE ELIGIBLE FOR ENROLLMENT BY PAYMENT OF A SURCHARGE IN ACCORDANCE WITH THE PCF RATE MANUAL

THIS INCLUDES THOSE WHO ARE EMPLOYED BY/AT THE ABOVE CORPORATION AND ANY ADDITIONAL LOCATIONS IN LOUISIANA OR HEALTH CARE FACILITIES IN LOUISIANA OWNED BY THE CORPORATION TO BE INCLUDED IN THE CORPORATE COVERAGE WITH THE PCF. PLEASE PROVIDE PHYSICAL ADDRESS IF DIFFERENT FROM THE CORPORATION'S ADDRESS THAT IS LISTED ABOVE. Continue on separate page if necessary.

Name & Address (use more than 1 line if needed)	Title and/or Association

NOTE:

No charge will be made to cover such entity if all owners, shareholders/partners and professional employees are qualified with the PCF. Otherwise a charge of 20% of each class rate will be made for shareholders/partners and employees not qualified in the PCF. A separate Certificate of Insurance is required that lists all enrolled health care providers in the Corporation/Partnership.

Does the corporation own other healthcare related facilities outside of LA (Please note that this is for informational purposes only and that the PCF cannot provide coverage for healthcare facilities outside of LA)? **YES / NO** please circle

If yes, in what states?_____

For Self Insured: I further certify that the appropriate security (proof of financial responsibility) is in place and current at _____; **or,**

For those with primary insurance, please provide a copy of the COI or declarations page from the insurer's policy evidencing coverage for the corporation.

SIGNATURE OF AUTHORIZED REPRESENTATIVE: _____

DATE: _____

CONTACT PERSON AND PHONE #:_____

CONTACT EMAIL ADDRESS:_____

Complete and return to: Patient's Compensation Fund (SURCHARGE DEPT) (866) 469-9555
P. O. Box 3718
Baton Rouge, LA 70821
Fax: (225) 362-5265